

**New Jersey Department of Health and Senior Services**

**Counseling and Testing Case Management Program**

**CASE MANAGEMENT MONITORING RECORD**

<b>Site Number</b>			<b>Case Manager</b>		
<b>From</b>  ____/____/____		<b>To</b>  ____/____/____		<b>CTS ID Number</b>  _____	
<b>Date</b>	<b>Contact Code</b>	<b>Service Code</b>	<b>Remarks</b>		

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**INSTRUCTIONS**

This form should be completed for each client enrolled in case management and placed in the client's folder. Fill in your site number, case manager name, CTS ID number of the client, and the dates this form covers.

Use the codes below to document each contact concerning the client. Use the REMARKS section to be more specific about the nature of the service. For example, if a client attended a battered women's support group meeting the entry would be as follows:

DATE: enter date of meeting  
CONTACT CODE: 6  
SERVICE CODE: n  
REMARKS: battered women's support group at (name agency)

If you provide additional HIV counseling and testing a new scannable form will have to be completed for the client. This will be noted on this form as follows.

DATE: enter date of pretest counseling  
CONTACT CODE: 2  
SERVICE CODE: b  
REMARKS: additional HIV counseling and testing CTS ID number \_\_\_\_

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**CONTACT CODES**

- 1 = phoned client for follow-up
- 2 = met with client
- 3 = accompanied/transported client to appointment
- 4 = phoned to make referral
- 5 = phoned to follow-up with referral source
- 6 = client kept referral appointment
- 7 = unsuccessful contact

**SERVICE CODES**

**MEDICAL**

- a. ob/gyn
- b. HIV
- c. dental
- d. drug/alcohol
- e. STD
- f. TB
- g. primary care
- h. other,  
specify \_\_\_\_\_

**PSYCHOSOCIAL**

- i. housing
- j. childcare
- k. job training
- l. legal assistance
- m. pastoral
- n. support groups
- o. financial
- p. food
- q. mental health counseling
- r. crisis intervention,  
specify: \_\_\_\_\_
- s. other,  
specify: \_\_\_\_\_